Opinion

E/M Changes for 2021: The Beginning, Not the End

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The E/M coding revisions aren't perfect, but they represent a huge step forward in reducing physicians' documentation burden, audit risk, and complexity of code selection.

This issue of *FPM* contains the final article in a three-part series on the 2021 changes to the outpatient evaluation and management (E/M) codes in CPT. (See the article on page 27.) Thoughtful readers of the prior articles[1,2] have pointed out several shortcomings and confusing aspects of the revised code set. While we doubt all questions and concerns will be put to rest, we would like to address many of them through our lenses as American Academy of Family Physicians (AAFP) advisors to the American Medical Association (AMA) CPT and Relative Value Scale Update Committee (RUC) processes.

THE CHANGES DIDN'T FIX EVERYTHING.

The E/M changes are not intended to alter coding patterns within or across specialties. The primary goal was to simplify the coding and documentation of office visits. Thus, the new structure eliminates history and exam as coding criteria and allows physicians to focus on medical decision making (MDM), or code based on total time. We should still document history and exam as appropriate for the care of our patients, but we don't have to factor them into code selection.

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A fair criticism is that those of us who actively manage three or more chronic conditions during an encounter are still performing more work than the minimum requirements for a level 4 visit. CPT tried to address this, but the number of specialties involved, the desire to minimize administrative burden, and the goal of keeping the MDM table as simple as possible got in the way. Should there be an additional billing level between 4 and 5? Probably. Unfortunately, actively managing multiple conditions is a concept foreign to most subspecialists who tend to dominate the CPT and RUC processes.

IT'S STILL HARD TO BILL A LEVEL 5 VISIT.

This criticism is true, although it may not be as hard as it used to be. Historically, many of us have coded acute complaints like melena or chest pain as level 4 because it was so burdensome (and often medically unnecessary for appropriate next steps) to perform and document all the history and exam elements needed to satisfy the requirements for a level 5 encounter. However, depending on the profile of the patient, such conditions may well represent a level 5 "acute illness that poses a threat to life or bodily function." So don't minimize the magnitude of your medical decision making on topics like this. The new coding rules make it easier to capture the work and risk (from the billing standpoint) when managing serious issues.

ABOUT THE AUTHORS

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Note: This article has been updated to reflect changes imposed by Congress in late 2020.

WHAT IF I DIDN'T PRESCRIBE A MEDICATION DURING THE VISIT, OR WHAT IF THE FINAL DIAGNOSIS IS A SELF-LIMITED ILLNESS?

Questions like these continue to arise related to moderate complexity, data, or risk to support level 4 billing codes, but some physicians are making this more difficult than it really is. If the patient takes a prescription medication but you did not address a condition pertaining to that medication during the visit, it doesn't count. On the other hand, if you did, for example, address hypertension and determine at the visit that no changes should be made to the medication dosing or no refill was necessary, then you still performed medication management, which includes a decision to continue a medication. You need to point out this work in your note — medication management without a new or revised prescription. Your coder cannot assume a connection between a medication on the list and your work; you need to make the connection clear.

If you are billing based on MDM, you can include decisions about prescription medications, but over-the-counter (OTC) medications generally don't meet moderate complexity. If you use OTC medications in that context, just state why the decision was higher risk. A prescription for an OTC medication for insurance coverage purposes does not meet this threshold.

If you are billing based on time, you can include the time spent counseling the patient regarding *any* medication options.

Also recall that code selection is not based on the final diagnosis, but on the medical decision making needed to reach that diagnosis. It is critical to document your thought process related to assessment and level of risk for patient management, as well as details of record and diagnostics review. This also includes the influence of social determinants of health, which may affect visit complexity.

WHAT ABOUT INFORMATION REVIEWED ON DAYS BEFORE OR AFTER THE VISIT?

If you are billing based on time, the only time that counts is time spent by the physician or other qualified health care professional on the same day of the visit. The new guidelines are a huge improvement from the previous face-to-face requirement, but they don't count time spent on another date.

However, if you are billing based on MDM, activity before or after the date of the visit does count toward the visit level.

ARE THE CHANGES ONLY FOR MEDICARE OR ALL PAYERS?

The new rules and definitions for outpatient E/M codes are present regardless of payer. The Centers for Medicare & Medicaid Services (CMS) proposed changes that led to the formal CPT revisions, which CMS agreed to follow. Most payers follow CPT, and some of the largest national payers have told the AAFP they intend to do so with the outpatient E/M changes. Of course, payment is a separate issue, so while other payers may follow CMS in honoring the CPT changes, the payment for commercial payers is based on negotiated contracts. The increased RVUs for E/M can serve as the basis for updating those contracts.

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Starting in 2021, CMS will increase values for E/M codes 99202-99215, as described in last year's Medicare Physician Fee Schedule. This year's Medicare Physician Fee Schedule will also increase values for additional categories of E/M services, including transitional care management services, cognitive impairment assessment, care planning, initial preventive physical examination, and initial and subsequent annual wellness

E/M CODING RESOURCES

AAFP Coding Reference Cards: 2021 Office Visit E/M Coding & Documentation: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/e-m-coding-reference-cards.html

Level of Medical Decision Making Table: https://www.aafp.org/fpm/2020/0900/p29.html#fpm20200900p29-ut2

2021 Office Visit E/M Vignettes Module: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management/vignettes-module.mem.html

visits. In all, the increased values for E/M codes, plus increases in the conversion factor, should equate to a payment increase of more than 10% for primary care physicians who participate in Medicare. (For more information, see the article on the 2021 Medicare Physician Fee Schedule: https://www.aafp.org/fpm/2021/0100/oa1.html.)

WHAT'S THE NEW GPC1X CODE?

G2211, formerly referred to as GPC1x, is a code CMS proposed to provide payment for primary care that's more commensurate with the costs of providing it. The agency states in the Aug. 17, 2020, proposed rule that, "Although we believe that the RUC recommended values for the revised office/outpatient E/M visit codes will more accurately reflect the resources involved in furnishing a typical office/outpatient E/M visit, we continue to believe that the typical visit described by the revised and revalued office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits." Code G2211 could be added to any new or established patient office visit when the intent is to provide continuity and/or comprehensive care. However, on Dec. 21, 2020, Congress delayed implementation of the code for three years as part of the 2020 year-end funding bill and COVID-19 emergency funding.

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WHAT ABOUT PAY EQUITY WITH OTHER SPECIALTIES?

The over-arching goal of the CPT E/M changes was reduction of administrative burden. After the office/outpatient E/M codes were revised by CPT, the RUC reviewed the new codes per its usual process, which involves surveying a sampling of physicians regarding the time and intensity of services provided. In this case, more than 50 of the AMA's medical specialties participated. In large part due to the volume of survey responses from family physicians, this survey was one of the most robust in RUC history. Based on those survey results, the RVUs associated with the majority of these E/M codes increased.

While pay equity wasn't the goal, the increase in relative values of outpatient E/M codes under the Medicare physician fee schedule effectively reduced the values of many other codes due to Medicare's budget neutrality provision. That's not "pay equity" per se, but it's a step in that direction.

WHAT'S NEXT?

As a result of the efforts of the AAFP and others, office/outpatient E/M coding is now simpler, and CMS (and potentially other payers) will pay more for some of those codes in 2021. There is more work to do, which is why the AAFP continues to advocate on multiple policy fronts to better recognize the value of family medicine in the delivery of high-quality health care. That includes being actively involved in the creation and valuation of CPT codes that describe work you perform that is not otherwise being recognized.

While the revised code set is imperfect and the updates to the E/M codes don't address every concern regarding payment, the tremendous amount of time and energy spent on these changes by your CPT and RUC teams has resulted in a substantial improvement in documentation requirements, as well as an increase in Medicare payments for these services. We hope that you will see the magnitude of this achievement as you gain experience with the new codes. We also hope that your thoughtful feedback will assist us with further revisions to these codes and further policy and advocacy efforts. You can send comments to fpmedit@aafp.org.

These changes mark the beginning, not the end, in our efforts to better recognize the work and value of family physicians. FPM

1. Millette KW. Countdown to the E/M coding changes. *Fam Pract Manag.* 2020;27(5):29-36.

2. Self C, Moore KJ, Church SL. The 2021 office visit coding changes: putting the pieces together. *Fam Pract Manag.* 2020;27(6):6-12.

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